Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, VA 23219

https://dmas.virginia.gov
MEDICAID MEMO

Last Updated: 03/09/2022

Implementation of the CMS - Affordable Care Act Provider Enrollment and Screening Requirements

The purpose of this memorandum is to inform providers that the Virginia Department of Medical Assistance Services (DMAS) will be implementing the new provider enrollment and screening regulations published by the Centers for Medicare and Medicaid Services (CMS). This is the first in a series of memos which will be released over the next several months.

This implementation is in response to directives in the standards established by Section 6401(a) of the Affordable Care Act (ACA) in which CMS requires all state Medicaid agencies to implement the provider enrollment and screening provisions of the Affordable Care Act (42 CFR 455 Subpart E). These regulations were published in the Federal Register, Vol. 76, February 2, 2011, and were effective March 25, 2011.

Initial and Ongoing Screening Requirements

All providers must now undergo a federally mandated comprehensive screening before their application for participation is approved or renewed by DMAS. Screening will also be performed on a monthly basis for any provider who participates with Virginia Medicaid. A full screening is also conducted at time of revalidation (see Revalidation section below). The required screening measures vary based on a federally mandated categorical risk level. Providers' categorical risk levels are defined as "limited", "moderate" or "high".

Limited Risk Screening Requirements

Limited risk provider types are physician or non-physician practitioners and medical groups, ambulatory surgical centers, renal facilities, federally qualified health centers, laboratories, hospitals, rural health clinics, skilled nursing facilities, residential psychiatric treatment facilities, adult day health care, private duty nursing, personal care, respite care, pharmacy, developmental disability waiver, and

consumer directed service coordination. The following screening requirements will apply to limited risk providers: (1) Verification that a provider or supplier meets any applicable Federal regulations, or State requirements for the provider or supplier type prior to making an enrollment determination; (2) verification that a provider or supplier meets applicable licensure requirements; and (3) Federal and State database checks on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type and that they are not excluded from providing services in federally funded programs.

Moderate Risk Screening Requirements

Moderate risk provider types are community mental health centers; comprehensive outpatient rehabilitation facilities; hospice organizations; independent clinical laboratories; ambulance services suppliers; revalidating home health agencies and suppliers of durable medical equipment, prosthetics and orthotics. In addition to those screening requirements applicable to the limited risk provider category listed above, the following screening requirements will apply to moderate risk providers: Unannounced pre-and/or post-enrollment site visits. The screening requirements listed in this section are to be performed at the time of initial enrollment and at the time of revalidation, which is at least every 5 years.

High Risk Screening Requirements

High risk provider types are newly enrolling home health agencies and suppliers of durable medical equipment, prosthetics and orthotics. In addition to those screening requirements applicable to the limited and moderate risk provider categories listed above, providers in the high risk category may be required to undergo criminal background check(s) and submission of fingerprints. These requirements apply to owners, authorized or delegated officials or managing employees of any provider or supplier assigned to the "high" level of screening. At this time, DMAS is awaiting guidance from CMS on the implementation of criminal background checks. More information will be forthcoming in future Virginia Medicaid communications regarding the requirement for criminal background checks and submission of fingerprints.

Online Enrollment and Updates

New providers who wish to participate with Virginia Medicaid will be directed to

complete electronic enrollments and/or updates through our web portal. If a provider is unable to enroll electronically through the web, they can download a paper application and follow the instructions for submission with the form.

We strongly encourage providers to enroll or make updates via our web portal once it is implemented. An application for participation submitted on paper will add additional time to the processing of your enrollment.

Application Fees

All newly enrolling (including new locations), re-enrolling, and reactivating institutional providers are required to pay an application fee. The fee requirement only applies to hospitals, hospice, nursing facilities, outpatient rehabilitation facilities, rural health clinics, federally qualified health centers, home health agencies, durable medical equipment providers, prosthetic/orthotic providers, independent labs, renal unit/renal dialysis clinics, residential psychiatric treatment facilities, emergency/air ambulance, emergency ambulance, and various other institutional provider types. If your provider class type is required to pay an application fee, it will be outlined in the Virginia Medicaid web portal.

The Centers for Medicare and Medicaid Services (CMS) determines what the application fee is each year. The application fee for fiscal year 2013 is $532. This fee is not required to be paid to Virginia Medicaid if the provider has already paid the fee to another state Medicaid program or Medicare, or has been granted a hardship exemption by Medicare. Virginia Medicaid will require proof of previous payment or exemption before the application or renewal can be processed.

Revalidation

All providers will be required to revalidate at least every 5 years. The revalidation of all existing providers will take place on an incremental basis and will be completed via our web portal.

DMAS is in the process of developing an online provider revalidation solution that

will allow providers to revalidate directly to DMAS online. The online process will be utilized to complete and submit revalidations, and will allow a provider the ability to track the status of their online revalidation.

Registration into the Virginia Medicaid web portal will be required to access and use the online enrollment and revalidation system. Information on how to register can be found below.

All existing providers enrolled in the Virginia Medicaid program will be notified in writing of their revalidation date and informed of their new provider screening requirements in the revalidation notice. If you are currently enrolled as a Medicare provider, DMAS may rely on the enrollment and screening facilitated by CMS to satisfy our provider screening requirements.

Ordering, Referring, and Prescribing (ORP) Providers

The Code of Federal Regulations 455:410(b) states that State Medicaid agencies must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

The ACA requires ordering, referring, and prescribing providers to enroll only to meet new ACA program integrity requirements designed to ensure all orders, prescriptions or referrals for items or services for Medicaid beneficiaries originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid. **The only exception to this requirement is if a physician is ordering or referring services for a Medicaid beneficiary in a risk-based managed care plan, the provider enrollment requirements are not applicable to that ordering or referring physician.**

If you are a provider who does not participate with Virginia Medicaid currently, but may order, refer or prescribe to Medicaid members, you must now be enrolled to ensure claims will be paid to the servicing provider who is billing for the service.

As a servicing provider, it is essential you include the National Provider Identifier (NPI) of any ORP provider on your claims to ensure the timely adjudication of your

claims.

New Billing Requirements and Edits

DMAS will establish new claim edits to ensure that all ORP provider NPI's are submitted on claims and that the NPI listed is actively enrolled in the Virginia Medicaid program. These new edits are:

Edit 0191: Provider Referral Required. This edit currently operates to reject claims from hospice providers who have members receiving inpatient care at a nursing facility. The new criteria being added are for providers to have a valid ordering/referring NPI on their claim. Please refer to Attachment A for the specific listing of these providers. Claims without a valid NPI will be denied.

Edit 0194: Attending Provider Not on File. This edit will validate that the attending provider indicated on the institutional (837I. Institutional DDE and Paper UB 04) claim has a valid NPI and is actively enrolled in the Virginia Medicaid program.

Edit 0195: Referring Provider Not on File. This edit will check that the NPI indicated on the claim is a valid NPI and enrolled in Virginia Medicaid.

Edit 0196: Referral Provider Not Eligible on Date of Service. This edit will reject the claim if the NPI listed is not enrolled and eligible with Virginia Medicaid for the date of service on the claim.

Edit 0197: Attending Provider Required. This edit will reject the claim if the Attending Provider NPI is not on the claim. DMAS has been requiring the Attending Provider NPI on claims but there was no edit prior to this implementation to validate participation with Virginia Medicaid.

Edit 0198: Attending Provider Same as Billing Provider. This edit checks that the Attending Provider is NOT the Billing provider since on the institutional claim, a

facility is expected to be the billing provider.

Edit 0199: Attending Provider Not Eligible on Date of Service. This edit will validate that the Attending Provider NPI is enrolled in Virginia Medicaid for the date of service on the claim.

At this time, there will be no new edits related to servicing providers or pharmacy claims. Pharmacy claims currently have an edit related to the prescribing NPI.

Newly Enrolling Providers

Newly enrolling providers are encouraged to utilize our on-line enrollment process once it is implemented. Through this enhanced process, providers will be able submit everything necessary for the enrollment to be processed, upload and attach necessary documentation, pay application fees (where applicable) and find out the status of their enrollment application. Going forward, the same portal will be utilized for updating changes in ownership, demographic information or to perform federally mandated revalidations.

First Time Registrations to the new Virginia Medicaid Web Portal

In order to gain access to the new online enrollment and revalidation enhancements, you must be registered in the Virginia Medicaid web portal. If you have not already registered for access to the Virginia Medicaid web portal, you may do so by visiting the site at www.virginiamedicaid.dmas.virginia.gov and establishing a user ID and password. By registering, you are acknowledging that you are the staff member who will have administrative rights for your organization. If you have any questions regarding the registration process, please refer to the Web registration reference materials available on the web portal. If you need further assistance, please contact the Xerox Web Registration Support Call Center, toll free at 1-866-352-0496, from 8:00

A.M. to 5:00 P.M. Monday through Friday, except holidays.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273 Richmond area and out-of-state long distance 1-800-552-8627 All other areas (in-state, toll-free long distance)

Please remember that the “HELPLINE” is for provider use only. Please have your Medicaid Provider Identification Number available when you call.